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THE DOCUMENT

This document has been in process for many years. From it's early beginnings in 1992 in Tucson, to it's completion in 2000, it is the result of the hard work, dedication, commitment, and future planning of many occupational therapists and physical therapists, educators, parents, and administrators from across the state of Arizona. Significant effort was made to include ideas from across the field for the document so that it truly reflects current practice in Arizona, as well as establishes best practice standards in occupational therapy and physical therapy in the school system.

Input was gathered from open forums held at the Arizona Occupational Therapy Association Annual Conference '95 and at the Arizona Directors' Institute '95, sponsored by the Arizona Department of Education, Exceptional Student Services.

Additionally, open town meetings were conducted in Phoenix, Tucson, Flagstaff, Yuma, Prescott, and Holbrook to offer the opportunity to any therapist, teacher, administrator, parent, or agency who wanted to provide ideas about what should and should not be in such a document. More than 150 people attended those meetings, providing comments, suggestions, and recommendations to the committee.

The draft document, in its second revision, was sent for review to the Arizona Board of Occupational Therapy Examiners and the Arizona Board of Physical Therapy. The Licensure Boards for OT and PT were not able to endorse the document, as it was not within their purview to do so. However, the Guidelines were considered recommended standards that, to the best of the committee's ability, meet and in some cases exceed the set statutory rules and requirements of the OT and PT Boards. Additionally, copies of the second draft were sent to the American Occupational Therapy Association and the American Physical Therapy Association for their review.

The Individuals with Disabilities Education Act Amendments of 1997 were signed into law in June of 1997. These amendments had many implications for OT and PT service delivery in the school system. This 2000 Guidelines document now reflects all new federal legislative mandates for related services as well as incorporates all the information gathered from all the resources listed above during the last 18 months. It is soundly based on federal and state laws, as currently known. As a technical assistance guide, it will need to be updated as the legislative rules and regulations change. For now, it serves as a starting point for guiding occupational therapy and physical therapy practice in the school systems in Arizona.

Disclaimer

This document is being published as a technical assistance document, by the Arizona Department of Education, to provide guidelines to therapists, parents, administrators, and teachers about procedures, available options, and considerations in regards to OT/PT services. The guidelines serve as recommendations for best practice based on federal regulations, state statutes and licensure laws in Arizona. The guidelines are not meant to interpret the law, as do the regulations, nor are they meant to be mandates.

I. INTRODUCTION AND PURPOSE

This document is intended to provide general guidelines to promote consistency in the service delivery of occupational therapy and physical therapy in the local education agencies in the state of Arizona. The guidelines are intended to be utilized by occupational therapists, physical therapists, certified occupational therapy assistants, physical therapy assistants, staff at the institutions of higher education, and school administrators. Since administrative procedures vary from school district to school district, these guidelines are designed to assist the districts in understanding the state licensure laws that govern these professions, as well as in implementing the practices that are supported by their professional organizations. This year 2000 guideline document reflects current federal legislation and state licensure laws and will be revised as the statutes and regulations change.

The major law that influences the quality of service for children with disabilities in the school setting is the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1400 et. seq.). In 1975, the Education of All Handicapped Children Act (EHA), Public Law 94-142 was passed "...to insure that all children with disabilities have available to them a free appropriate public education which includes special education and related services to meet their unique needs" (34 CFR 300.1 (a)). The law applied to children five to twenty one years of age who required special education. In 1986, P.L. 99-457 amended the EHA and required special education and related services for children with developmental delays from three to five years of age. The amendment also provided incentives to states to provide services to infants and toddlers with developmental delays. In 1990, the EHA was reauthorized, revised, and renamed the Individuals with Disabilities Education Act (IDEA)(P.L. 101-476).

On June 4, 1997, President Clinton signed the IDEA Amendments of 1997. This new law created the fifth set of amendments to the country's landmark education legislation, EHA, and now focuses on students with disabilities needing access to the general education curriculum, involving families to a greater extent in their children's education, supporting professional development, and directing resources to teaching and learning.

Occupational therapy and physical therapy are two of the related services that may be necessary to assist in the education of children with disabilities in order for the child to benefit from special education. In Arizona, school-based therapists provide services to children in special education ages 3-21.

The laws that apply to special education and related services in the public school setting are comprehensive and flow from federal and state statutes down to local school district/charter school policies and procedures. Therapists working in the school system should become familiar with the laws governing special education. The federal law IDEA (20 U.S.C. 1400 et. seq.) and the related regulations (34 CFR, Parts 300 and 301) and the state statutes- Arizona Revised Statutes, Title 15 (ARS 15-761 to 15-772). Additionally, occupational therapists should become familiar with the rules and regulations of the Arizona Board of Occupational Therapy Examiners. Physical therapists should review the rules and regulations set forth by the Arizona Board of Physical Therapy. (Copies of these rules and regulations can be obtained from the individual state licensure boards.) Finally, occupational therapists and physical therapists are responsible for knowing and understanding the policies and procedures set forth by the Local Education Agency (LEA) Governing Board.

Interaction between occupational therapy and physical therapy:

It is important to point out that although the professionals in occupational therapy and physical therapy may use similar activities, each discipline has its own area of expertise. The related services of occupational therapy and physical therapy that a student receives should support the student's educational program to ensure an effective educational experience, as indicated in the student's IEP. The two professions are complementary; however, as stated in their individual state licensure laws (ARS, Chapter 32, PT and Chapter 34, OT), only an occupational therapist may provide occupational therapy services and only a physical therapist may provide physical therapy services.

II. SPECIAL EDUCATION DEFINITIONS

In the interest of consistency, it is important that there is a shared understanding of terms addressed in this document; therefore, the following definitions are provided.

A. **SPECIAL EDUCATION:** Special education means specially designed instruction at no cost to parents, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings; and instruction in physical education. (34 CFR 300.26)(See Appendix A for special education categories in Arizona).

B. **INDIVIDUALIZED EDUCATION PROGRAM (IEP):** The individualized education program means a written statement for a child with a disability that is developed, reviewed, and revised in a meeting in accordance with 34 CFR 300.341-350. The IEP serves as a communication vehicle, commitment of resources, management tool, compliance monitoring document, evaluation device, and opportunity for resolving differences.

C. **RELATED SERVICE:** According to IDEA, related service means transportation and such developmental, corrective, and other support services as are required to assist a child with a disability to benefit from special education and includes speech-language pathology and audiology, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including parent counseling and training, rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in school, and parent counseling and training (34 CFR 300.24 (a)).

D. **LEAST RESTRICTIVE ENVIRONMENT (LRE):** This is another important provision of the law that impacts the practice of occupational therapy and physical therapy in school settings. Least restrictive environment means that to the maximum extent appropriate, children, including children in public or private institutions or other care facilities, are educated with children who are non-disabled; and that special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily (34 CFR 300.550 (b)).

Occupational and physical therapy services should be provided within the context of the child's educational program, keeping in mind the spirit of least restrictive environment. In order to integrate occupational therapy and physical therapy services effectively within the school setting, occupational therapists and physical therapists must understand special education and local school district programs and policies.

III. THERAPY AS A RELATED SERVICE

A. OCCUPATIONAL THERAPY:

1. DEFINITIONS:

Federal regulations from the IDEA define occupational therapy as services provided by a qualified occupational therapist, which include improving, developing, or restoring functions impaired or lost through illness, injury, or deprivations; improving ability to perform tasks for independent functioning if functions are impaired or lost; preventing, through early interventions, initial or further impairment or loss of function (CFR 300.24 (b)(5)).

The Arizona Board of Occupational Therapy Examiners defines occupational therapy as the use of occupational therapy services with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, socioeconomic and cultural

differences, or the aging process in order to achieve optimum functional performance, maximize independence, prevent disability, and maintain health including evaluation, treatment, and consultation (ARS, Chapter 34, Article 1, Section 32-3401.5).

The American Occupational Therapy Association (AOTA) defines the practice of occupational therapy as the therapeutic use of purposeful and meaningful occupations (goal-directed activities) to evaluate and treat individuals who have a disease or disorder, impairment, activity limitation, or participation restriction which interferes with their ability to function independently in daily life roles and to promote health and wellness (AOTA, 1999).

2. OCCUPATIONAL THERAPY SERVICES IN THE SCHOOLS:

School-based guidelines published by AOTA, "Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Education Act," state that OT services are client-centered and recognize the client's needs, wants, and priorities. Within the school environment, the client may represent a single individual, such as the student, the teacher, or the parent. The client may also be a group of people, such as the entire IEP team, the school staff, or the district bus drivers who need training in proper lifting and handling techniques (AOTA, 1997).

This dramatic shift in thinking moves occupational therapists away from being a primarily direct service provider into fulfilling more inclusive roles such as consultants, program developers, and trainers, in seeking compliance with the least restrictive environment mandate (DiMatties, 1994**).** Additionally, the mandate of IDEA '97 emphasizes the delivery of services within the general education curriculum. Therefore, OTs may need to take on a greater role as consultants than in the past. Occupational therapy services delivered to students, or on behalf of students, must be considered within the therapist's realm of work. Service delivery involves the therapist and the client in a collaborative process of designing and implementing the best child environment that fits.

3. OT PERFORMANCE AREAS:

Performance areas are broad categories of human activity that are typically part of daily life. The American Occupational Therapy Association delineates performance areas for school-based occupational therapists that define the areas of practice in school systems (AOTA, 1994c). These areas include: 1) activities of daily living (grooming, oral hygiene, toilet hygiene, dressing [as related to school performance], feeding and eating, socialization, functional communication, and functional mobility); 2) work and productive activities (educational activities, vocational activities, and home management such as meal preparation, shopping, or clothing care; and 3) play or leisure activities (play or leisure exploration and play or leisure performance).

The performance components that may be addressed by occupational therapy when required for a student to participate in school activities and remain in the least restrictive environment include:

PERFORMANCE COMPONENTS	EDUCATIONAL PURPOSE
Neuromuscular and Musculoskeletal Systems Range of Motion	To enable the child to participate in school activities and remain in the least restrictive environment
Control of muscle tone and integration of developmentally appropriate reflexes and reactions as basis for more normal movement	
Muscle strength/ endurance and postural control/alignment	To increase strength and stability for performing daily routines in school

MOTOR

Gross coordination	To increase accuracy and speed as needed for movement within the school environment and for completing school activities
Crossing midline/laterality	
Bilateral coordination	
Motor planning	
Fine coordination/dexterity	
Visual motor integration	
Oral motor control	

SENSORY PROCESSING

Integration of tactile, visual auditory, vestibular, proprioceptive, and kinesthetic input	To facilitate the child's ability to effectively process and respond to basic sensorimotor information as a foundation for the acquisition and development of motor skills and for the organization of attention and behavior
Body scheme	
Position in space	
Spatial relations	
Right/left discrimination	
Form constancy	
Pain response	

COGNITIVE INTEGRATION

Level of arousal/attention	To permit the child to use higher level of brain function to achieve maximum benefit from classroom instruction and peer interaction
Orientation/recognition	
Memory/sequencing	
Problem solving/generalization	

PSYCHOSOCIAL SKILLS AND PSYCHOLOGICAL COMPONENTS

Self -Concept	To enable the child to interact with peers and educational staff in ways necessary to function in the educational setting
Values/Interests	
Interpersonal skills	
Self expression	
Time management	
Coping skills/Self Control	

The occupational therapist, as a member of a IEP team, will participate in the IEP development and decision-making process relating to goals and objectives, frequency and duration of services, placement, and the monitoring of the IEP.

In Arizona, within educational settings, an occupational therapist may evaluate and implement a program plan without a physician's referral. Should the school district receive a referral for occupational therapy services from a physician, the referral must be considered by the IEP team and recommendations for therapy services will be based on educational need.

If a student has an identifiable occupational therapy need that does not affect the student's ability to learn and benefit from the educational experience, that therapy is not the responsibility of the local educational agency.

4. RECOMMENDED COMPETENCIES:

a **OT** - The following are recommended competencies adapted from AOTA, 1990, which meet (and in some cases exceed) requirements set forth by the Arizona Board of Occupational Therapy Examiners in ARS 32-3401.6. Best practice would suggest that advanced competencies such as the supervision of OTAs or occupational therapy students, comprehensive evaluations of assistive technology needs, using specialized techniques for severe feeding/swallowing disorders, etc., would require further training, education, and experience.

1. Knowledge of disabling conditions that occur before and after birth and their effects on students with special needs related to educational performance.

2. Knowledge of the educational system and its critical components including federal and state regulations and ethical/legal responsibilities applying to occupational therapists in the educational setting.

3. Knowledge of major theories, treatment procedures and research relevant to providing occupational therapy services for children (infants through age 21) with disabilities.

4. Ability to assess the functional performance of students with disabilities within the school environment.

5. Ability to interpret assessment results appropriately and use the results to develop therapeutic intervention plans and classroom strategies appropriate to the educational goals for the student.

6. Ability to communicate effectively (both orally and in writing) with educational personnel, parents, local and state agencies, and the community at large.

7. Ability to engage in consensus decision-making as part of the IEP process in order to write appropriate IEP goals and objectives.

8. Ability to plan and implement intervention strategies using a continuum of service delivery approaches in accordance with student needs.

9. Ability to evaluate, modify, and document the effectiveness of occupational therapy intervention as it relates to the student's education program.

10. Ability to facilitate transition among agencies, programs, and professionals as service

provision changes (early intervention to preschool, preschool to school age, and school to work).

b **OTA -** The following are recommended competencies adapted from AOTA, 1990, which meet (and in some cases exceed) requirements set forth by the Arizona Board of Occupational Therapy Examiners in ARS 32-3401.6.

1. Knowledge of disabling conditions that occur before and after birth and their effects on students with special needs related to educational performance.

2. Knowledge of the educational system and its critical components including federal and state regulations and ethical/legal responsibilities applying to occupational therapists in the educational setting.

3. Knowledge of occupational therapy treatment procedures and therapeutic activities relevant to providing occupational therapy services for children, ages 3 to 21, who have disabilities.

4. Ability to relate observations of student performance to performance components of learning activities, in order to effectively grade activities and positively impact the educational program of students with disabilities within the school environment.

5. Ability to collaborate with occupational therapy personnel in the collection of data for the occupational therapy comprehensive assessment, including review's of student files, interviews with referring sources, and observations of student performance.

6. Ability to communicate effectively with educational team members in implementing appropriate therapeutic intervention plans and classroom strategies as developed by the supervising occupational therapist.

7. Ability to participate in consensus decision-making as part of the IEP process in collaboration with the supervising occupational therapist to develop appropriate IEP goals and objectives.

8. Ability to document service contacts and maintain student therapy files, according to district and/or therapy department procedures.

9. Ability to facilitate transition between agencies, programs, and professionals as service provision changes (early intervention to preschool, preschool to school age, and school to work).

10. Ability to problem-solve creative solutions for student programs coupled with the ability to seek supervision from occupational therapy supervisor when appropriate.

11. Ability to utilize a variety of adaptive equipment and positional devices and/or to modify classroom supplies for student educational program.

B. PHYSICAL THERAPY

1. DEFINITIONS:

Federal regulations from the IDEA define physical therapy as those services provided by a qualified physical therapist (34 CFR 300.16 (b)(7)).

The Arizona Board of PT defines the practice of PT as:

a Examining, evaluating and testing persons who have mechanical, physiological and developmental impairment, functional limitations and disabilities or other health and movement related conditions in order to determine a diagnosis, a prognosis and a plan of therapeutic intervention and to assess the ongoing effects of intervention.

b Alleviating impairments and functional limitations by designing, implementing and modifying therapeutic intervention including:

i Therapeutic exercise.

ii Functional training in self-care and in home, community or work reintegration.

iii Manual therapy techniques.

iv Therapeutic massage.

v Assistive and adaptive orthotic, prosthetic, protective and supportive devices and equipment.

vi Pulmonary hygiene.

vii Debridement and wound care.

viii Physical agents or modalities.

ix Mechanical and electrotherapeutic modalities.

x Patient related instruction.

c Reducing the risk of injury, impairments, functional limitations and disabilities by means that include promoting and maintaining a person's fitness, health and quality of life.

d Engaging in administration, consultation, education and research.

2. PHYSICAL THERAPY SERVICES IN THE SCHOOLS:

The physical therapist practicing in an educational setting must be a currently licensed therapist holding entry-level credentials from an accredited physical therapy program.

Within the educational model, physical therapists assist special education students with the development and practice of motor and postural control, safety and mobility in the educational environment, sensory processing, or other underlying performance components that significantly impact the student's educational experience. Physical therapists may also assist with equipment needs and communicate with community agencies on behalf of the student. A student may require physical therapy intervention to benefit from special education, to be maintained in the least restrictive environment, or to be assisted in the development and implementation of an accommodation plan under Section 504 of the Rehabilitation Act of 1973.

Although certain disabling conditions cause motor dysfunction, the student may receive physical therapy through the school system only if the condition and movement problem interferes with the student's educational experience and performance. This interference must be identified and documented by the multidisciplinary evaluation team.

Educational physical therapy services may include screening, assessment, program planning, intervention, communication, consultation, education, and documentation.

3. PT PERFORMANCE AREAS:

a physical access to educational activities

b movement requirements for daily living and self care

c prevocational physical requirements

d access to school play and recreation activities and equipment

e physical management components related to psycho-social development, functional communication, and transportation to and from school.

Specific student performance areas that may be addressed by physical therapy when required for a student to participate in school activities and remain in the least restrictive environment include:

a Neuromuscular and Musculoskeletal systems (range of motion, control of muscle tone, muscle strength, endurance, gross motor coordination, motor planning).

b Sensory processing related to equilibrium and protective reactions, proprioceptive, and kinesthetic input, and bilateral coordination.

c Functional communication (classroom positioning, recommendations for adaptive devices or equipment).

d Environmental adaptations (evaluations and recommendation for modifications of architectural barriers and children's equipment).

e Posture and positioning (symmetry of positions, handling and transfer methods).

f Adaptive equipment (skin care, recommendations for splints, bracing, and positioning devices).

g Functional mobility (transfer skills, gait evaluation and recommendations, wheelchair mobility).

h Mobility and transfer skills, adaptive equipment, wheelchair and equipment care, and use for self help.

i Physiological function (functional muscle strengthening, cardiorespiratory function and fitness, body mechanics, energy conservation techniques).

j Prevocational and vocational skills (generally strengthening, sitting and standing tolerance, motor coordination, adaptive equipment).

k Education/communication (information on disability and educational impact, staff training and development, liaison between medical and education staff). (Martin, 1992)

The physical therapist, as a member of a IEP team, will participate in the IEP development and

decision-making process relating to goals and objectives, frequency and duration of services, placement, and the monitoring of the IEP.

Within the educational setting in Arizona, a physical therapist may evaluate and implement a program plan without a physician's referral. Should the school district receive a referral for physical therapy services from a physician, the referral must be considered by the IEP team, and recommendations for therapy services will be based on educational need.

If a student has an identifiable physical therapy need that does not affect the student's ability to learn and benefit from the educational experience, that therapy is not the responsibility of the local education agency (i.e. a child with a sports injury/cast continues to learn although he or she may be uncomfortable in the school environment). Accommodations should be considered if a student qualifies under Section 504.

4. RECOMMENDED COMPETENCIES FOR PTS:

The following are recommended competencies that meet (and in some cases exceed) requirement set forth by the Arizona Board of Physical Therapy.

a Knowledge of the educational system and its critical components, including the federal and state regulations and the ethical/legal responsibilities that apply to physical therapists in the educational setting.

b Knowledge of disabling conditions that occur before and after birth, as well as the effects on students as related to educational performance.

c Knowledge of major theories, treatment procedures, and research relevant to providing physical therapy services for children (infants through age 21) with disabilities.

d Ability to assess the functional performance of students with disabilities within the school environment. This would include identifying, comparing, selecting, and administering appropriate evaluations.

e Ability to interpret assessment results appropriately and use the results to develop therapeutic intervention plans and classroom strategies appropriate to the educational goals for the student. This could include adaptive equipment, assistive technology devices, and outside professional consultation.

f Ability to communicate effectively (both orally and in writing) with educational personnel, parents, local and state agencies, and the community at large.

g Ability to engage in consensus decision-making as part of the IEP process in order to write appropriate IEP goals and objectives.

h Ability to plan and implement intervention strategies using a continuum of service delivery approaches in accordance with student needs in the least restrictive educational environment.

i Ability to evaluate, modify, and document the effectiveness of physical therapy intervention as it relates to the student's educational program.

j Ability to facilitate transition among agencies, programs, and professionals as service provision changes (early intervention to preschool, preschool to school age, and school to work).

k Evidence of continuing educational efforts to enhance skills, expertise, and professional knowledge as it relates to job performance. This could include such areas as adaptive and assistive technology, training and supervision of other staff, administration, and time management.

C. THERAPY SERVICES UNDER THE IDEA:

1. EARLY INTERVENTION SERVICES:

Early Intervention for infants and toddlers (birth through two years of age) is provided for in Part C of the IDEA. Under the provisions of Part C, states have a system for providing services to infants and toddlers with disabilities and development delays and their families. The federal government provides grants to the designated lead agencies responsible for the development and implementation of these services. In Arizona, the Department of Economic Security, DES/AzEIP is the designated lead agency for early intervention services to AzEIP eligible children birth through age two.

Under the Part C early intervention program, all AzEIP children receive service coordination services in addition to other services identified on the Individualized Family Service Plan (IFSP). The focus is clearly on the needs of the child within the family unit, with emphasis placed on the central role of the family in the design, implementation, and coordination of services (AOTA, 1996).

In Arizona, the transition from early intervention services to preschool programs is significant for many families. Going from a system where children may receive services in the context of the family and community to a school-based model where related services (i.e. OT and/or PT) may be provided in groups in the classroom setting is often difficult to understand and accept. Transition requirements ensure a team (teachers, early intervention providers, school district representatives, related service providers) work collaboratively with families to plan and provide for a smooth transition to the public school setting. Advanced planning for the transition should begin as soon as appropriate (starting when the child is 2.6-2.9 months of age). This advanced planning often relieves much of the anxiety for the parents and helps to start the preschool experience on a positive note.

2. PRESCHOOL THROUGH AGE 21 SERVICES:

Preschool through age 21 educational services from occupational and/or physical therapy are considered a related service as is required to assist a child with a disability to benefit from special education (34 CFR 300.24 (a)). The least restrictive environment is addressed in the delivery of related services to preschool and school age children in special education. Often these services are provided within the context of the classroom or playground environment (in naturally occurring settings) with groups of children, rather than the one-to-one service model. Decisions relating to service delivery are always determined by the IEP team to best meet the educational needs of the individual child.

3. SECONDARY TRANSITION SERVICES:

Secondary transition services, according to the IDEA '97 Amendments, are planned for special education students beginning at age 14. The term, transition services means a coordinated set of activities for a student with a disability that are designed within an outcome-oriented process, which promote movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation (34 CFR 300.29(a)(1)). The occupational therapist and physical therapist may play a role as team members in transition planning for these students, taking into account the individual needs of the students, their preferences, and interests. Related service providers may find themselves part of the student's

community experience, assisting in the acquisition of daily living skills and functional vocational evaluations, or they may need to assist in adaptations and access to employment and other post school living opportunities.

4. INCLUSION SERVICES:

The least restrictive environment decision-making process is the legal process for determining the least restrictive and most appropriate placement for students. Inclusion is a term reflecting the current educational position that all individuals, regardless of ethnicity, race, age, religion, gender, sexual orientation, or disability should be a part of the naturally occurring activities of society. Inclusion addresses the need for all individuals to have the same opportunities. It also recognizes the benefit to everyone of being with individuals who are different from themselves (AOTA, 1995).

Within the school setting, inclusion is seen when a student with significant disabilities is placed in a general education classroom with support services to assist the student in meeting the IEP goals. The OT and/or PT can provide adaptive and compensatory strategies to increase the student's performance in mobility, access to environments, activities of daily living, work, play, and leisure. The interventions they use include the use of activities designed to improve performance, as well as identify adaptive equipment, environmental modifications, and alternative methods necessary to support improved function. In working with students who are included, OTs and PTs, because of their professional background and training in neurological conditions, often become key members of the team. Collaborating with other educational professionals and parents, they assist in access to interventions and services to support the student in the general educational setting.

5. ASSISTIVE TECHNOLOGY SERVICES:

Assistive technology may assist a student in special education in accessing a free appropriate public education (FAPE). Occupational therapists and physical therapists may play a major role in the school systems in determining assistive technology needs for many students. The term assistive technology device can mean any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability (34 CFR 300.5). Assistive technology services means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. This term includes the evaluation of the needs of such a child (including a functional evaluation of the child in the child's natural environment) in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing the devices (34CFR 300.6). Assistive technology devices may include augmentative devices, environmental controls, computers, and modifications to buildings. However, the assistive technology does not always have to be expensive or elaborate. It can be as simple as adaptive eating utensils, inclined planes, adapted pencils, modified books and stories, or Velcro picture boards. Assistive technology services encompass technical assistance and training for children with disabilities and their families, as well as coordination of such services. Technical assistance/resource information can be acquired by contacting the Arizona Department of Education, Exceptional Student Services.

D. MEDICAL THERAPY MODEL AND SCHOOL-BASED THERAPY MODEL DIFFERENCES

	MEDICAL MODEL	SCHOOL-BASED MODEL
Goal	To treat the client's continuum of needs (from acute through rehabilitation status).	To assist a student with a disability to attain educational goals.
Frequency	As needed.	Based on the educational needs as specified on the IEP.
Caseload	5-20 clients depending on acute or rehabilitation status.	62% of OT's serve 25-50 children for 1 FTE (full time equivalent), depending on location, service delivery model, and supervisory responsibilities. (1996 AZ OT survey).
Provider	Therapist.	Therapist.
Implementers of Home or Educational Program	Family, Care Provider.	Teacher, Aide, Peers, Family.
Duration of Intervention	A few days to several months.	Based on educational needs as specified on the IEP typically at least one year. services may be discontinued after a year or two, then begin again when the student's educational needs change.
Ultimate decision made by	Doctor, therapist, and client.	IEP team with therapist's input.
Intervention	Direct service with some family consult concerning recommendations and provision of the IEP including equipment.	An array of services as defined in the IEP. It may include hands-on services, consultation, equipment management, inservice training, etc.
Place	Clinic, hospital, home.	Naturally occurring environments, as appropriate.

IV. ASSESSMENT AND IDENTIFICATION

A. DOCUMENTATION:

Documentation is essential for good communication and accountability of the occupational therapist's and the physical therapist's actions. Documentation should conform to federal, state, and local education agency requirements. Educational relevance of all therapy services should be clearly documented. Documentation provides physical evidence for the therapy program's service delivery to students. Documentation includes: assessment, present level of performance, annual goals, and short term objectives; and level of service, duration, and frequency.

Each local educational agency should identify procedures and forms that document the process from referral to placement for students identified as needing special education and related services.

Documentation should include referral for occupational therapy and/or physical therapy; parental permission for initial evaluation and prior written notice for initial and re-evaluation (including procedural safeguards); evaluation; determination of eligibility for services by the evaluation team; development of an individual education program (IEP); progress reports; IEP review/revision; and documentation of classroom adaptations/modifications.

1. Referral Documentation:

Written documentation of a referral is needed and should include demographic information about the student, a reason for the referral and the identification of the specific concerns in one or more of the following areas: sensorimotor, psychosocial, self care, and cognitive. The referral should also contain a statement regarding how the concerns impact the child's education. Therapists are responsible for the time lines established in 34 CFR, part 300; ARS 15-761 to 15-771; the Arizona Administrative Code (AAC) relating to special education; and district policies and procedures. Close attention should be given to procedures regarding parent notification and permission to evaluate.

2. Evaluation Documentation:

An occupational therapy and/or physical therapy evaluation may be a component in a comprehensive psycho-educational evaluation report or it may be an individual, stand alone evaluation. For detailed information regarding the components of a comprehensive evaluation, refer to the *AZ-TAS Themes and Issues: Comprehensive Evaluation for Special Education* published by the Arizona Department of Education, Exceptional Student Services. If the occupational therapy and/or physical therapy evaluation is part of a comprehensive evaluation, the occupational therapist and/or the physical therapist should consult with the primary evaluator (generally the school psychologist) to determine the components of the evaluation that the therapist is required to provide as part of the evaluation report. The information gathered should address the discrepancies observed by the therapist pertaining to the child's environment, academic performance, and ability to access the general curriculum and classroom. The therapist should use professional judgment in determining the extent of the evaluation.

The evaluation process may include assessment in the neuromuscular, motor, sensory processing, cognitive integration, and psycho-social performance components. It is the role of the therapist to determine which performance areas and components are relevant in assessing the student. The assessment should be conducted to answer the questions that generated the referral. Evaluation tools may include criterion-referenced tests, standardized and non-standardized tests, performance assessments, curriculum-based assessments, and various performance-based checklists.

A comprehensive evaluation report should identify and include:

a Demographic information.

b Reason for referral.

c Background information (educational history and previous interventions).

d Family history (component of a comprehensive psychoeducational evaluation).

e Educationally relevant medical information and developmental history.

f Verification from a medical doctor for students identified as orthopedically impaired (OI) and other health impaired (OHI), verification from an ophthalmologist for students identified as visually impaired (VI), and verification from an audiologist for a student identified as hearing impaired (HI).

When selecting instruments and procedures, a variety of assessment tools and strategies should be used to gather relevant functional and developmental information. Classroom and campus-based assessment strategies may include: self-evaluation questionnaires, student interviews, functional observations of performance (structured, informal checklists), and parent and teacher interviews. No single procedure should be used.

Assessment procedures (behavioral observations [functional performance for the motor components], interviews, review of records, and previous test instruments used).

Results and interpretation (observational and test results).

Statement of other effects (lack of instruction in reading or math, and limited English proficiency (34CFR 300.534 (b)).

Summary should include how student's abilities, and any discrepancies between ability and performance, affect that student's functioning within the general education curriculum, as indicated in the evaluation.

Statement of disability criteria (Does the evaluation data indicate that the student meets the criteria under 34CFR 300.7 (a)?)

Recommendations should include information related to enabling the child to be involved and progress in the general education curriculum and stated in a way that the IEP team can develop appropriate goals and objectives, address instructional strategies, and other recommendations, as appropriate.

The evaluation report is forwarded to the IEP team for eligibility determination. It is recommended that all evaluators attend the IEP meeting to share information with the parents. The comprehensive evaluation report should be secured in the student's confidential student file, not in the cumulative file. (*AZ-TAS Themes and Issues: Comprehensive Evaluation for Special Education)*

The IEP team determines eligibility for special education and related services based upon the existence of a disability and an adverse effect on the child's educational performance. Eligibility is not a decision made by one individual.

3. IEP Documentation:

The Individualized Education Program (IEP) is the vehicle used for communication between the parents and the school district. It serves as a commitment of resources, a management tool, a compliance monitoring document, an evaluation device and an opportunity for resolving differences.

The components of an IEP must include:

- A statement of present level of educational performance (including sensorimotor, self-help, and psychosocial, if appropriate) and how the child's disability affects the child's involvement and progress in the general education curriculum.

- A statement of measurable annual goals including benchmarks or short-term objectives.

- Evaluation procedures and schedules for determining whether the goal(s) and benchmarks/ objectives are being achieved.

- A statement of special education and related services and supplementary aids and services to be provided to the child or on behalf of the child.

- An explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and school activities.

- A statement of any individual modifications in the administration of state or district-wide assessments of student achievement.

- Date of initiation of services and modifications.

- Anticipated frequency, location, and duration of services.

- Statement of the least restrictive environment with justification for LRE.

- A statement of how the annual goals will be measured and how the child's parents will be regularly informed of their child's progress (at least as often as nondisabled children's progress is reported).

- Beginning at age 14, and updated annually, a statement of the transition service needs of the child.

- Date of the IEP meeting.

Participants at the IEP meeting must include the parent, a representative of the public agency who is qualified to provide or supervise the provision of special education and who is knowledgeable about the general curriculum, the special education teacher, the regular education teacher (if the child is, or may be, participating in the regular education environment), and the child with a disability, whenever appropriate. If the parents do not attend, even after documented attempts (at least three) to involve them, there must be a third person in attendance at the IEP meeting. The occupational therapist and/or physical therapist should be present at the IEP meeting; however, when this is not possible, information can be shared with the appropriate staff member who will attend the IEP meeting and be able to share the therapy information with the IEP team.

On initial placement in special education (first time placement) a placement statement must be signed by the parent. This placement statement provides parental permission to provide services to the student. Prior written notice, including the procedural safeguards, must be provided to the parents for the initial permission to evaluate, to determine eligibility, to develop the IEP meetings (initial and annual review), to place initially in special education, to reevaluate, and any other time the IEP team proposes to initiate or change the evaluation, identification, IEP, and/or placement of a student in special education.

B. CONSIDERATIONS WHEN DETERMINING THE NEED FOR OCCUPATIONAL THERAPY AND/OR PHYSICAL THERAPY:

(Section B is adapted with permission from DiMatties, Marie E., et. al. *"Putting the Pieces Together: A Model for School Based Occupational Therapy,"* 1995.)

1. Personal Needs:

Skills that permit the management of personal care needs in the educational community and future work environment.

Intervention may be indicated when:

- Basic attention to task and organization of self within the educational environment is limited due to an impaired ability to process and use sensory information.

- Student's successful integration into the school environment is limited due to lack of staff or peer understanding of the medical and/or physical condition.

- Management of feeding, clothing, and personal hygiene is affected by sensorimotor/ neurodevelopmental deficits or lack of maturational prerequisites.

- Task completion or skill acquisition requires adaptive equipment, adaptive strategies, or modified environment.

- Task analysis of task and subsequent training in component parts.

- Management of student's personal care needs must be completely or partially performed by support staff, and training is required.

- Student's ability to direct teacher or caretaker in performing necessary routine is inadequate (i.e. student's knowledge of needs and ability to translate to caretaker).

2. Manipulation of School-related Materials:

Motor skills as prerequisites for successful, efficient manipulation and use of classroom tools and materials.

Intervention may be indicated when:

- Basic attention to task and organization of self within the educational environment is limited due to an impaired ability to process and use sensory information.

- Student's successful integration into the school environment is limited due to lack of staff or peer understanding of the medical and/or physical condition.

- Effective and functional use of toys, switches, crayons, pencils, scissors, and other educational materials is affected by inefficient eye-hand coordination.

- Manipulative tasks such as using scissors, catching a ball, tying shoes, stringing beads, playing musical instrument, etc., are affected by inefficient coordination of both body sides.

- Completion of fine motor activities in a time-efficient manner is difficult due to inadequate shoulder, arm, hand, and/or finger strength or endurance.

- Functional use of arms/hands is affected by limited range of motion.

- Manipulative tasks such as writing, picking up small objects, opening a combination lock, completing art projects, and using other educational materials are affected by inefficient dexterity and hand skills.

- Orientation to paper, development of hand dominance, letter formation, and other such activities are affected by limitations in crossing the body's midline.

3. Movement and Postural Control:

Motor skills as prerequisites for combining movements necessary for control, coordination, and transitions in the educational environment.

Intervention may be indicated when:

- Basic attention to task and organization of self within the educational environment is limited due to an impaired ability to process and use sensory information.
- Student's successful integration into the school environment is limited due to lack of staff or peer understanding of the medical and/or physical condition.
- Assuming and maintaining positions during activities and making movement transitions are affected by sensory/neuromuscular status.
- Functional use of the hands is affected by inadequate trunk control, and limitations in strength, range of motion, or endurance.
- Visual attending to learning activities is affected by inadequate head control.
- Performing physical activities without tiring and actively meeting the demands of the environment are impaired due to inadequate strength and endurance.
- Efficient and functional performance of motor tasks and adaptive responses are affected by motor planning abilities.
- Maintaining and/or regaining body position during movement is affected by inadequate balance and postural responses.
- Student's accessibility to the school environment and learning opportunities requires assistive technologies, which may include adaptive devices, equipment, materials, alternative seating, positioning, and/or removal of architectural barriers.
- Student's successful integration and participation in the educational environment require staff training in the use and/or care of specific adaptive devices and/or equipment.

4. Social and Self Management:
The ability to meet the social and emotional demands of the educational environment.

Intervention may be indicated when:

- Basic arousal and attention to task within the educational environment is limited due to impaired ability to process and use sensory information.
- Self control and ability to modify behavior is limited due to impaired ability to process and use sensory information.
- Interpersonal skills and ability to interact in a variety of interpersonal situations is limited due to impaired ability to process and use sensory information.
- Organization of self and materials within the educational environment is limited due to impaired ability to process and use sensory information.

5. Communication and Interaction with Teachers, Family, and Friends Associated with Motor/ Sensorimotor Development:
Communication of ideas, needs, information, and opinions to others by writing or through the use of alternative devices/methods

Interventions may be indicated when:

- Basic attending to task and organization of self within the educational environment is limited due to impaired ability to process and use sensory information.

- Student's successful integration into the school environment is limited due to lack of staff or peer understanding of the medical and/or physical condition.

- Functional written communication skills are deficient due to lack of maturational or neuromotor/sensorimotor prerequisites.

- Functional written communication requires student/teacher training with assistive technology to include alternative communication devices, adaptive equipment, or modified procedures.

6. Transition Skills:

Functional living skills to prepare for vocational pursuits, life in the community, participation in recreational and leisure interests, and for performing independently in the home environment.

Intervention may be indicated when:

- Basic attention to task and organization of self within the educational environment is limited due to impaired ability to process and use sensory information.

- Student's successful integration into the school environment is limited due to lack of staff or peer understanding of the medical and/or physical condition.

- Task completion may require the development or adaptation of organizational skills for successful job performance.

- Successful use of work site may require adaptation or modification.

- Functional use of work tools may require specific adaptation of tools.

- Successful interaction with the community may require development/improvement of social skills and adaptation or modification of tools or equipment necessary for the community interaction to take place.

C. CONSIDERATIONS WHEN OCCUPATIONAL THERAPY AND/OR PHYSICAL THERAPY MAY NOT BE INDICATED:

Interventions may not be indicated when:

- Staff are aware of and understand implications of the student's medical and/or physical condition and are managing the student's environment appropriately.

- Deficits do not interfere with the student's ability to function adequately within an educational setting.

- Student has learned appropriate strategies to compensate for deficits.

- Functional living skills are not goals of student's special educational program.

- Modifications to the school or work environment have been made and are effective.

- Current level of achievement is consistent with other areas of development.
- Assistive technology is available, is in working order, and is effective. Staff have been instructed in its use and care.
- Therapy services have been provided, but deficits continue to exist. Therapy is no longer affecting change in the student's level of function or rate of skill acquisition.
- Needed strategies can be implemented effectively by current educational team and continued occupational therapy and/or physical therapy intervention is not required.
- Demands for written communication are within the capabilities of the student in his/her placement.
- Modifications to testing procedures or written communication formats have been make and are effective.
- The student has adequate motor development to control and coordinate movements.
- The student is demonstrating progress toward IEP goals and objectives/benchmarks without support of related services.

V. INTERVENTION

A. COLLABORATIVE TEAMING:

OTs and PTs must always strive to think in terms of collaborative teaming. It is best practice for sharing in the successes and minimizing the failures for the students they serve. Collaborative teamwork has been defined as work accomplished jointly by a group of people in a spirit of willingness and mutual reward (Rainforth, York, and McDonald, 1992). In the public school system, this teamwork gets accomplished by a group of people that centers around a student. The team should always include the parent, the child (if appropriate), and the student's teachers. Additional professionals on the team may include the psychologist, social worker, educational consultant, nurse, principal, and other related providers (i.e. speech therapist). In a true collaborative team model, all members become committed to teaching, learning, and working with each other across traditional disciplinary boundaries (York, 1992). They often share information with each other through role release so the skills the student needs to learn and practice throughout the day/week/year are taught by the people who spend the most time with the student. Effective teams are bonded by a common framework and philosophy of education (Ginagreco, 1990). They recognize that building a team takes time and requires a willingness to communicate and interact openly. Members respect the unique expertise of each individual on the team and value the sharing of input for the benefit of the student. Everyone on a team should have an equal voice, but not necessarily the same perspective.

As part of the team, the OT and PT share responsibility for identifying priorities, strengths and needs, planning strategies and goals for educational performance, and anticipating outcomes for the future. In order for this to happen, it is imperative that the related service providers become familiar with the general education curriculum and convey to teachers how services can assist the student to participate more fully.

The need for related services should be a team decision, based on the needs of the student and the areas of expertise of the staff. Decisions are made by consensus. Plans formulated by the team are carried out until a revision of the plan is made by the team. Realistically, because of varying opportunities for

inservice training, background experience in teaming, and philosophical differences, not all members of a team are at the same level of sophistication, understanding, and commitment to a collaborative team model. Logistical problems relating to time and resources may also present barriers to collaboration. In spite of these realities, a team approach with a comprehensive plan for delivery of services is in the best interest of the student.

B. ADAPTATIONS, MODIFICATIONS, AND ACCOMMODATIONS:

Through a collaborative process, team members identify a child's present level of educational performance and determine how a child's disability affects his or her involvement and progress in the general education curriculum. This process leads to the development of adaptations. Adaptations include accommodations and modifications and are based on an individual student's strengths and needs. Accommodations are provisions made in how a student accesses and demonstrates learning. These do not substantially change the instructional level, the content, or the performance criteria. The changes are made in order to provide a student equal access to learning and equal opportunity to demonstrate what is known.

Modifications are substantial changes in what a student is expected to learn and to demonstrate. Changes may be made in the instructional level, the content, or the performance criteria. Such changes are made to provide a student with meaningful and productive learning experiences, environments, and assessments based on individual needs and abilities.

C. MODELS OF RELATED SERVICE DELIVERY:

Service provision issues have long been discussed among therapists, administrators, parents, and other agencies providing services to students. By law, the agency or district must indicate the initiation date, the anticipated frequency, duration, and location of the occupational therapy and/or physical therapy services to be provided on the child's behalf. The IDEA does require that the amount of time commitment must be appropriate to the specific service and stated in the IEP in such a manner that is clear to all who are involved in both the development and implementation of the IEP (34 CFR Appendix A, Question 35).

1. CONTINUUM OF SERVICES:

In order to best meet the individual needs of students, occupational therapists and physical therapists must provide a continuum of services to the children they see. All types of services that an OT and/or PT provides to a student or on behalf of a student should be considered intervention (AOTA, 1997) as long as it is clearly described in the IEP. It is critical that the service delivery model chosen by the IEP team reflect the student's educational needs as outlined in the IEP.

Direct Service: Hands-on or direct services are provided by the occupational therapist and/or physical therapist while assessing the student, developing and modeling classroom strategies, solving problems, and/or modifying programs. Direct services are also provided in situations where specialized input by a skilled service provider is determined to be the most appropriate model of service for the student. These services can be delivered through individual, small group, and/or whole class activities. Individual contacts may require an isolated setting for a short period of time; however, the focus of any pull-out service model is to return the student to the naturally occurring setting as soon as possible. Integrating therapy into the classroom routine provides opportunities for the student to learn functional motor, communication, and other skills as part of the natural routines in integrated school and community environments (Rainforth, York, McDonald, 1992). School-based therapists work in the natural environments of individual students. These may include the classroom, cafeteria, library, bathroom, playground, hallways, and/or other specialty areas on the school grounds and in the community. Direct services should include some level of indirect/consultative services with other team members to ensure that specialized input is incorporated into daily activities and routines. The direct service option must be considered,

discussed, and used to meet the individual needs of the student. It is considered the most intrusive service option. The decision not to use this model cannot be made based upon personnel shortages or uncertainty regarding the availability of staff.

Consultation Services: In addition, the therapist may utilize general training, observation of student performance, monitoring of performance data, and development of materials to adapt the curriculum. These types of indirect services are no less important to a student's success than hands-on service. Consultation service refers to the reciprocal exchange of information where the primary recipients of the service are other team members. It involves the exchange of ideas and skills among team members (including parents) that are related to the educational program for a specific student. It can include spending time on behalf of the student with student-related activities such as fabrication of materials, adaptation of classroom materials, and/or home/hospital/clinic visits with the student, as long as it is clearly documented in the IEP.

In addition to providing services to, for, or on-behalf of a given student, there are a number of additional tasks and activities that should be considered as part of the workload of an occupational therapist or a physical therapist. These include documentation of evaluations, progress notes, home programs, letters to physicians or agencies, and communications via phone calls related to student services, multidisciplinary team meetings, and staffing conferences. These services should be considered as important supportive activities as they require time, professional expertise and experience, and collaboration between team members (AOTA, 1997).

2. STAFF DEVELOPMENT/TECHNICAL ASSISTANCE:

Staff development/technical assistance refers to a variety of services that are infrequent and of short duration and may be outside the special education IEP process. This is an interactive process that enables people with diverse expertise to generate creative solutions to mutually defined problems (Rainforth, York, McDonald, 1992). Staff development/technical assistance in the educational environment should be directed to professional needs or system needs (AOTA, 1987). Three components of staff development/technical assistance are conferring with school personnel, making periodic student checks, and providing equipment modification or repair on an as-need basis, whether the student is placed in special education or not.

a Case/Colleague Collaboration: The result of this collaboration may include curriculum adaptations and classroom or environmental modifications, or it may generate a referral for an occupational therapy and/or physical therapy assessment.

b Periodic Student Check: The therapist may follow up on a student who previously received related services or who is considered at high risk but is not currently receiving related service.

c Equipment Consultation: Some students require periodic adjustments or repair of adapted equipment or supplies used in their educational setting. Therapists may be consulted on an as-need basis for students whose equipment needs repairs and who may not be receiving related services.

When selecting a staff development/technical assistance model, it is critical for administrators and therapist to communicate and work closely together to ensure that the need of all students in special education identified as receiving OT and/or PT are met and the allocation of resources is available and appropriate for the implementation of this model.

D. <u>PROGRESS REVIEW AND REEVALUATION:</u>

Student progress toward achieving the IEP annual goals and benchmarks or objectives is reviewed by the occupational and physical therapist at a variety of levels throughout the child's school years.

1. Periodic reassessment of the student's progress toward current IEP benchmarks/objectives is reported to parents at the same time as nondisabled peers, allowing revisions as needed.

2. Annual review and reassessment of the student's progress toward his or her annual goals and current benchmarks or objectives is done when the IEP is being reviewed. Therapists document student progress and determine the extent to which the annual goals have been achieved.

3. Every three years, or at a time sooner if the IEP team feels it is appropriate, the child's eligibility for special education services and need for related services must be determined. At this time, the IEP team is charged with reviewing the existing data to see if any additional tools or strategies may be needed to determine eligibility. Additional questions may or may not require additional testing for continued eligibility. Written parental consent must be obtained before a reevaluation can be undertaken by the educational team.

E. DISCONTINUATION OF THERAPY SERVICES:

(This section is adapted with permission from DiMatties, Marie E., et. al.
"Putting the Pieces Together: A Model for School Based Occupational Therapy," 1995.)
The decision as to whether a child continues to need occupational therapy and/or physical therapy services follows a review of the existing evaluation data on the child, including evaluations and information from parents, current classroom assessments and observations, and teacher and related service observations. On the basis of this review, the IEP team determines if the child continues to need related services.

Factors which may be taken into account when considering whether a child continues to need occupational and/or physical therapy services include:

1. Has the student developed the performance components needed to progress toward the educational goals established in the IEP?

2. Have environmental or curricular adaptations been established to allow for achievement of educational goals?

3. Are the student's needs being met by others at this time and no longer require the skilled services of a therapist?

4. Has the educational setting changed and is the student functional within this setting?

5. Has the student learned appropriate strategies to compensate for deficits?

6. Is assistive technology now available, in working order, and is it effective? Has staff been instructed in its use and care?

7. Is therapy no longer affecting change in the student's level of function or rate of skill acquisition?

Discontinuation of therapy services is an IEP team decision and should be reflected in the student's IEP. Prior written notice and procedural safeguards to parents must accompany this decision. Documentation of this discontinuation of therapy services should include a summary of student progress and a statement of how current levels of functioning affect student involvement and progress in the general education curriculum.

VI. OT/PT PERSONNEL AND ADMINISTRATIVE ISSUES

A. QUALIFICATIONS OF OT AND PT PERSONNEL

1. **Occupational Therapist (OT) and Occupational Therapy Assistant (OTA):** The individual practicing occupational therapy in the state of Arizona must hold a valid and current license. The practice and licensure of occupational therapy is regulated by the Arizona Board of Occupational Therapy Examiners, who has established the following requirements for licensure as an occupational therapist or as an occupational therapy assistant (ARS 32-3423).

   a The candidate is of good moral character and has not been convicted of a crime of moral turpitude.

   b The candidate has successfully completed the academic requirements of an educational program in occupational therapy recognized by the Arizona Board of OT Examiners.

   c The candidate has successfully completed a period of supervised fieldwork experience approved by the board, which consists of a minimum of 24 weeks for an OT and a minimum of 8 weeks for a OTA.

   d The candidate has successfully passed a written examination given by the National Certification Board in Occupational Therapy, Inc., for either the OT or the OTA.

   e The candidate holds a current license from the Arizona Board of OT Examiners as an OT or as a OTA. The renewal of licensure requires documentation of continuing education every two years.

   f Only therapists certified by the National Board of Certification in Occupational Therapy, can use the initials OTR/L or COTA/L after their name to indicate their professional qualifications.

2. **Physical Therapist:** The individual practicing physical therapy in the state of Arizona must hold a valid and current license. The practice and licensure of physical therapy is regulated by the Arizona Board of Physical Therapy, who has established the following requirements for licensure as a physical therapy practitioner (ARS 32).

   a The applicant shall be of good moral character and shall have satisfactorily completed an accredited physical therapy education program as determined by the board.

   b The board shall issue to an applicant meeting the standards set by the board, a physical therapist license after successfully completing the examination the board deems necessary to determine the fitness of the applicant to practice physical therapy and record the name of the licensee on its records.

   c The licensed physical therapist will hold a current Arizona license by renewing the license every two years.

3. **Physical Therapy Assistant:** The Arizona Board of Physical Therapy does not currently issue a license to physical therapy assistants. A physical therapy assistant is a person who is a graduate of a physical therapy assistant education program accredited by the Commission on Accreditation in Physical Therapy Education, as determined by the Board of Physical Therapy.

B. RESPONSIBILITIES OF OT AND PT PERSONNEL:

The OT, OTA, and PT have important but distinct roles in the school setting. The purpose of this section is to provide clarification of the roles in the provision of qualified services.

1. OT: The occupational therapist has the ultimate responsibility for OT service provision.

a Evaluation Responsibilities

- Determines the evaluation information to be collected and the methods and instrument to be used.
- Administers assessment tools and data collection procedures related to areas of expertise.
- Analyzes and interprets information gathered in evaluation.
- Synthesizes, summarizes, and reports information to appropriate individuals.
- Determines the need for reevaluation.

b Program Planning and Implementation of Intervention

- Contributes to the IEP process and assists in writing goals and objectives related to specialized instruction.
- Develops and coordinates intervention plans.
- Implements the intervention plan directly or in collaboration with others.
- Monitors the student's response to intervention and modifies the plan as needed.
- Communicates and collaborates with other educational team members, family, or caregivers.
- Recommends discontinuation of services, as part of the IEP team decision, when maximum benefit is received. Formulates follow-up plans.

c Documentation of Services

- Maintains records required by regulatory agencies and the school system.
- Updates, at least annually, IEP goals and objectives and the student's current status.
- Maintains the occupational therapy student file.

d Clinical Supervision

- Establishes service competency with the OTA for all tasks delegated.
- Provides supervision for the OTA in accordance with the OTAs level of skill and role performance (see Supervision of OT Personnel).
- Provides functional supervision to co-workers in areas of experience and expertise.

2. **OTA:** The occupational therapy assistant must function under the supervision of an OT at all times and must establish service competency in all areas that are delegated by the OT.

a Evaluation

Assists with data collection and evaluation, including chart reviews and interview of referral sources and shares observations of performance in educational environments.

- With documented training and documented demonstration of service competency, OTAs may conduct certain aspects of standardized assessment, such as administering specific tests like the TVMS for visual motor skills.
- Alerts the OT of changes in student status that might warrant reevaluation.

b Implementation of Intervention

- Assists the OT in the IEP process by sharing observations of student's performance, particularly in the development of the IEP goals and objectives.
- Implements and coordinates intervention plan under the supervision of the OT.
- Monitors the student's response to intervention and seeks supervision from the OT to modify intervention plan(s) as needed.
- Communicates and collaborates with other educational team members and the student's family or caregivers under the supervision of the OT.
- Alerts the OT to changes in student status of equipment and adapted devices.

c Documentation of Services

- Provides OT with current data regarding the student's overall status.
- Assists the OT in documentation of the permanent education record.
- Maintains student records regarding occupational therapy services.

d Clinical Supervision

- Establishes service competency with the OT for delegated tasks related to caseload.
- Monitors own performance, identifies supervisory needs, and seeks out supervisor when appropriate.
- Engages in supervisory relationship with the OT in accordance with the OTAs level of skill and role performance (see Supervision of OT Personnel).

3. **PT:** The physical therapist has the ultimate responsibility for PT service provision in the educational setting.

a Evaluation Responsibilities

- Determines the evaluation information to be collected and the methods and instruments to be used.

- Administers assessment tools and data collection procedures related to areas of expertise.
- Analyzes and interprets information gathered in evaluation.
- Synthesizes, summarizes, and reports information to appropriate individuals.
- Determines need for reevaluation and participates in periodic reevaluations.

b Program Planning and Implementation of Intervention

- Contributes to the IEP process.
- Develops and coordinates intervention plans.
- Implements the intervention plan directly or in collaboration with others.
- Monitors the student's response to intervention and modifies plan as needed.
- Communicates and collaborates with other educational team members, family, or caregivers.
- Recommends discontinuation of services, as part of IEP team decision, when maximum benefit is received. Formulates follow-up plans.

c Documentation of Services

- Maintains records required by regulatory agencies and the school system.
- Updates at least annually the information in the permanent file, which reflects the student's current status.
- Maintains the working student file.

d Clinical Supervision

- The physical therapy assistant's role is defined by physical therapy law in Arizona as assisting, under the on-site supervision of a physical therapist, in the practice of physical therapy, and performing delegated procedures commensurate with the assistant's education and training. The physical therapy assistant does not evaluate, interpret, design, or modify established treatment programs.

C. SUPERVISION AND ROLES OF OCCUPATIONAL THERAPY PERSONNEL:

1. OCCUPATIONAL THERAPY PERSONNEL: Supervision is a collaborative process to promote, establish, maintain, or elevate a level of performance and service. In the school setting there are often two types of supervision for occupational therapy personnel.

Supervision of occupational therapy is regulated by Article 4 of the Rules of the Arizona Board of Occupational Therapy Examiners. For the purposes of these guidelines, the word "student" has been substituted for the words "client" and "patient."

a Administrative Supervision - This type of supervision is generally provided by an

educational administrator and addresses adherence to general policies, procedures, and operations of the school system.

b **Professional Supervision** - This type of supervision is generally provided by another occupational therapist who monitors all aspects of the occupational therapy program. Large therapy departments often identify an occupational therapy program coordinator for the purpose of supervision. The type of professional supervision required is closely linked to both the role and the level of expertise in the role.

Types of professional supervision include: close supervision (the supervising occupational therapist provides initial direction to the occupational therapy assistant and daily contact while on the premises); routine supervision (the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 15 calendar days on a per-student basis while on the premises, with the supervising occupational therapist available by telephone or by written communication); general supervision (the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 30 calendar days on a per-student basis while on the premises, with the supervising occupational therapist available by telephone or by written communication); and minimal supervision (the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least every 30 calendar days while on the premises) (R4-43-101).

2. OCCUPATIONAL THERAPY ASSISTANTS:
Only a licensed occupational therapist shall:

a Prepare an initial OT intervention plan, initiate or re-evaluate a student's OT intervention plan, or authorize a change in that intervention.

b Delegate duties to a licensed occupational therapy assistant, designate an assistant's duties, and assign a level of supervision.

c Authorize discharge from OT if the IEP team determines a discharge to be appropriate (R4-43-401A).

A licensed occupational therapy assistant shall not:

a Evaluate or develop an OT intervention plan independently.

b Initiate an OT intervention plan before a student is evaluated and an intervention plan is prepared by an occupational therapist.

c Continue an OT intervention plan appearing to be harmful to a student until the procedure is reevaluated by an occupational therapist.

d Continue or discontinue OT services unless the OT intervention plan is approved or re-approved by a supervision occupational therapist (R4-43-401B).

A supervising occupational therapist shall supervise a licensed occupational Therapy assistant as follows:

a Not less than routine supervision if the occupational therapy assistant has less than 12 months work experience in a school setting or with a particular skill.

b Not less than general supervision if the occupational therapy assistant has more than 12 months but less than 24 months of experience in a school setting or with a particular skill.

c Not less than minimal supervision if an occupational therapy assistant has more than 24 months of experience in a school setting or with a particular skill.

d Increased level of supervision, if necessary, for the safety of a student (R443401C).

These levels of supervision are minimum, and the OT responsible for supervision shall assign a more restrictive level of supervision if deemed necessary for the safety of a student (R4-43-101.10). Finally, it is recommended that the supervising OT maintain a written record of the supervision plan and meetings for each occupational therapy assistant under the OT's supervision.

3. OCCUPATIONAL THERAPY AIDES:

An occupational therapy aide shall not provide occupational therapy services in any setting. However, an occupational therapy aide may provide supportive services assigned by an occupational therapist or occupational therapy assistant after the aide is specifically trained to provide the supportive services by an occupational therapist.

An occupational therapy aide cannot act independently and shall receive continuous supervision (i.e. the occupational therapist is in the immediate area of the aide performing the supportive services).

The occupational therapy aide shall not perform the following tasks:

a Evaluate a student.

b Prepare OT intervention plans.

c Make entries in the student records about the student's status.

d Develop, plan, adjust, or modify intervention plans.

e Interpret referrals for OT services.

f Continue a task if there is a change in a student's condition.

g Perform any task without adequate training or skills.

h Perform any task requiring licensure under A.R.S. 32-3401-3445 (R4-43-402).

4. UNLICENSED PERSONNEL: Certified occupational therapy assistants and physical therapy assistants may be employed as instructional aides in the school setting. It is important to note that instructional aides are supervised by teachers. If certified occupational therapy assistants or physical therapy assistants are employed as instructional assistants they cannot represent themselves as occupational therapy assistants or physical therapy assistants or they cannot represent their work as occupational therapy or physical therapy.

5. THE ROLE OF THE CLASSROOM TEACHER AND EDUCATIONAL AIDE:

The role of the educational staff is to implement strategies and interventions devised by the therapist

that allow the student to practice the skills several times within natural environments and contexts. Techniques and strategies are incorporated into a classroom program plan and may include features such as the use of the therapist's knowledge to identify a need related to a problem in school performance, the design of a strategy to address the identified need, a plan for implementation by the student and/or others in a variety of appropriate contexts throughout the school environment, and follow up to determine the effectiveness and need for continued implementation of the plan. The implementation of this classroom program plan is not considered part of the therapy as delineated on the IEP. It is merely part of the educational programming for the student. Both the teacher and the therapist share responsibility for this intervention.

D. SUPERVISION OF PHYSICAL THERAPY PERSONNEL:

1. Supervision is a process to promote, establish, maintain, or evaluate a level of performance and service. In the school setting there are often two types of supervision for physical therapy personnel.

a. Administrative Supervision is the type of supervision that is generally provided by an educational administrator and addresses adherence to general policies, procedures, and operations of the school system.

b. Professional Supervision is the type of supervision that may be provided by another physical therapist who monitors all aspects of the physical therapy program. Large therapy departments often identify a Physical Therapy Program Coordinator for the purpose of supervision. The type of professional supervision required is closely linked to the role and the level of expertise in the role.

2. Unlicensed Personnel- The supervising physical therapist is responsible for all physical therapy care given by assistants, aides, and attendants.

a. The physical therapy assistant's role is defined by statute in Arizona as "a person who assists under the on-site supervision of a licensed physical therapist in the practice of physical therapy and who performs selected and delegated procedures and related tasks commensurate with the assistant's education and training but who does not evaluate, interpret, design or modify established treatment programs." (ARS, Chapter 32-2043)

b. The physical therapy aide is unlicensed and has no formal training in therapeutic techniques or equipment modifications. Aides may perform designated routine tasks with on-site supervision by a licensed physical therapist. Based on ARS, Chapter 32, no one shall work as a physical therapy assistant except under the on-site supervision of a licensed physical therapist.

3. Physical therapy service frequency as listed on the student's IEP reflects the amount of time the licensed physical therapist or PT Assistant in involved with that student and does not include daily classroom programs carried out by teacher an/or educational staff. (ARS, 32-2043)

4. The Role of the Classroom Teacher and Educational Aide(s)
The role of the educational staff is to implement strategies and interventions devised by the therapist that allow the student to practice the skills several times within the natural environments and contexts. Techniques and strategies are incorporated into a classroom program plan and may include features such as: the use of the therapist's knowledge to identify a need related to a problem in school performance; the design of a strategy to address the identified need; a plan for implementation by the student and/or others in a variety of appropriate contexts throughout the school environment; and follow up to determine the effectiveness and need for continued implementation of the plan. The implementation of this classroom program plan is not considered

part of the therapy as delineated on the IEP. It is merely part of the educational programming for the student. Both the teacher and the therapist share responsibility for this intervention.

VII. SECTION 504 AND THE ADA

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 Title II address the issue of a student with an identified disability (eligible or not eligible for special education under the IDEA) who is having difficulties participating in and benefiting from the educational program. These children might need to receive occupational and/or physical therapy services as reasonable accommodations in the general education setting. Both Section 504 and the ADA provide protection against discriminatory practices on the basis of disability. Under Section 504 and/or the ADA, occupational therapy and physical therapy must focus on the student's educational performance within the school (educational**)** environment, as does intervention under the IDEA. Under Section 504 there is no individual education program; rather, an accommodation plan is developed by an educational team. The plan documents and defines specifically what accommodations and adaptations are needed and will be implemented in the student's educational program.

Section 504 states that any student who is currently disabled cannot be denied or excluded from services if services are needed in order for the student to benefit from a free appropriate public education (29 U.S.C., Section 794). The definition of disability in Section 504 and the ADA is much broader than the categories of disability specified in the IDEA. Section 504 identifies individuals as disabled who have a physical or mental impairment which substantially limits a major life activity, has a record of such an impairment, or is regarded as having such an impairment (29 U.S.C., Section 706[8]). The ADA utilizes a similar definition of disability in 28 CFR, Part 36. Under Section 504 and the ADA, occupational therapy and physical therapy practitioners in public schools may work with the non-special education teams to provide the necessary accommodations for non-special education students as deemed appropriate. Each local education agency must have a Section 504 coordinator and established policies and procedures.

VIII. ADDITIONAL CONSIDERATIONS

A. SCHEDULING:

Team members need to be flexible when scheduling, in order to meet a student's needs. Integrated programming can support student's success. Intervention may need to be provided in a variety of settings: academics, lunch, recess, and specials (art, PE, or music).

Therapists may help the student accomplish goals more effectively by using a variable time frame rather than the traditional hands-on, 30 minutes per week. To accomplish the flexibility, it is often helpful to indicate the frequency as: minutes per week, minutes per month, or minutes per semester. It may be appropriate to specify in the IEP more intense therapist services early in the school year, fading to less intense services as the year passes and routines are established across programs and activities of the school day (Kentucky, 1995). Whatever the frequency of the service, it is important that this is made clear to the entire team, including the parent, and the frequency is clearly documented in the IEP.

Block scheduling is a current trend in service delivery that provides a variable time schedule (Rainforth, 1992). Using this model the therapist can vary types of intervention and the duration and intensity of services.

An example of a variable time schedule follows. Flexibility from month to month is reflected on an IEP that calls for two hours of occupational therapy per month. Month one may include: 20 minutes hands-on intervention during handwriting in the classroom (week one); 10 minutes intervention in the classroom and 20 minutes consultation with the teacher (week two); 15 minutes intervention during art and 35 minutes consultation with the parent (week three); 15 minutes intervention during PE and 5 minutes intervention during toileting (week four). Month two may include: 1 hour intervention in the classroom

(week one); 1/2 hour consultation with the teacher and 1/2 hour intervention in the classroom (week three)(DiMatties, 1995).

Block scheduling does not indicate a range of service time (e.g. 30-90 minutes per month) as ranges of time are not acceptable on the IEP.

B. CASELOADS:

Occupational therapists and physical therapists should work closely with the special education director for the best fit of caseload and service delivery. The national professional organizations for OTs and PTs provide suggested best practice guidelines for caseloads. According to a 1996 survey conducted by the Arizona Occupational Therapy Association, sixty-two percent of all full-time OTs have caseloads ranging between 25-50 students. Thirty-one percent have caseloads between 51-99 students, and seven percent see more than 100 students. Seventy-four percent of those responding felt that caseloads of more than 50 students are too high.

It is important to remember that caseloads will vary with the school or district's practices. The following are some of the factors to consider in determining the number of students the occupational therapist or the physical therapist can adequately serve; travel distance and time; number of referrals for screening and evaluations; assessment and documentation requirements; number and referrals for screenings, evaluations and trainings in assistive technology; complexity of individual student's needs; model of interventions used; efficiency of the system (i.e. communication between team members, availability of secretarial services); amount of time needed for collaboration with educational staff and parents; amount of time needed for community and medical contacts; experience or training of the therapists; and other responsibilities such as supervision of other professionals, paraprofessionals, and students (Pennsylvania, 1995).

C. SAFETY:

It is important for the school-based OT and PT to be familiar with district policies and procedures. Although policies and procedures vary from district to district, being familiar with them will assist the therapist in becoming more aware of educational safety concerns. Many safety problems can be prevented by the therapists being familiar with the school campus, the transportation system, evacuation procedures, and community-based environments.

Along with the school nurse, the therapist is frequently the team member most qualified to inservice educational staff regarding medical conditions and/or precautions relating to the physical status of a student (i.e. the OT or the PT may be the most qualified to train staff in the proper lifting and handling techniques specific to a student with a mobility impairment).

D. LIABILITY:

Many physical therapists and occupational therapists carry malpractice insurance. The method of employment determines the type of coverage that may be needed by a PT or an OT. The level and scope of authority within the employment agreement should be understood and documented. Therapists are personally liable for activities outside their designated scope of authority (Iowa, 1993).

E. EQUIPMENT AND SUPPLIES:

A variety of equipment and materials are needed to assist students in achieving their individual educational goals and objectives. All equipment and supplies need to be age-appropriate for students. The following list includes some of the capital expenditures and supplies that may be needed.

1 Student specific equipment identified as assistive technology is important in the delivery of services. This may include such items as feeding utensils, specialized positioning equipment, slanted writing surfaces, and educational learning materials (i.e. assistive communication devices). Expendable items may include Velcro, foam, Dycem, and pencil grips.

2 Therapy program equipment may be needed such as therapeutic balls, bolsters, mats, or vestibular boards.

3 Assessment tools and standardized tests are equipment needs of therapists.

4 Infection control supplies are essential. As students with more intense medical needs and students who are developmentally younger enter school, hygienic maintenance is a concern. Younger children (i.e. preschoolers) may require increased efforts at infection control because of mouthing, drooling, etc. Examples of hygienic supplies are disposable gloves and antibacterial soap.

5 Clerical and office equipment and supplies are also needed by therapists. Such items as file cabinets, office furniture, and computers assist in efficient service delivery and documentation.

6 System equipment, such as handwriting curriculums and modified playground equipment, affects the entire educational system.

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APPENDIX A

A "child with a disability" is a child who is at least three but less than twenty-two years of age, who has been evaluated pursuant to ARS 15-766 and found to have at least one of the following disabilities and who, because of the disability, needs special education and related services:

a) Autism.
b) Emotional disability.
c) Hearing impairment.
d) Other health impaired.
e) Specific learning disability.
f) Mild, moderate, or severe mental retardation.
g) Multiple disabilities.
h) Multiple disabilities with severe sensory impairment.
i) Orthopedic impairment.
j) Preschool moderate delay.
k) Preschool severe delay.
l) Preschool speech/language delay.
m) Speech/language impairment.
n) Traumatic brain injury.
o) Visual Impairment.

(ARS 15-761[2])